**Senate File 2121 - Introduced**

SENATE FILE 2121
BY JOHNSON

## A BILL FOR

An Act authorizing the commissioner of insurance to develop individual and small employer basic benefit health care plans for certain young adults and their dependents.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF IOWA:

Section 1. NEW SECTION. **505.32 Individual and small employer basic benefit health care coverage.**

1. The commissioner of insurance, in cooperation with carriers interested in participating, shall by rule develop individual and small employer health insurance plans providing basic benefit coverage targeted for sale to individuals under thirty years of age, and their eligible dependents, who have not had health care benefits within the preceding twelve months.

2. The health insurance plans developed shall provide basic levels of primary, preventive, and hospital care for covered individuals, including inpatient hospitalization coverage, prenatal care, obstetrical care, a basic level of primary and preventive care, and such other coverages as the commissioner may determine are cost effective.

3. A basic benefit coverage policy or subscription contract shall include a disclosure statement which includes but is not limited to an explanation of those mandated benefits and providers not covered by the policy or contract, the managed care and cost control features of the policy or contract, and the period of time the policy or contract remains in effect.

4. All basic benefit coverage policy forms including applications, enrollment forms, policies, subscription contracts, certificates, evidences of coverage, riders, amendments, endorsements, and disclosure forms shall be filed with and approved by the commissioner before a basic benefit coverage policy or subscription contract is issued or issued for delivery in this state.

5. Basic benefit coverage policies or subscription contracts shall return a cumulative loss ratio as determined by the commissioner.

6. Each carrier providing a basic benefit coverage policy or subscription contract in this state shall maintain separate and distinct records of enrollment, claim costs, premium income, utilization, and other information as required by

the commissioner. Each carrier providing such policies or contracts shall furnish an annual report to the commissioner. The report shall be in a form prescribed by the commissioner and shall contain information required by the commissioner to analyze the success of insurance coverage issued pursuant to this section.

7. The commissioner may, upon reasonable actuarial evidence as to cost effectiveness, make determinations regarding any of the following:

*a.* What benefits or direct pay requirements must be minimally included in a basic benefit coverage policy or subscription contract.

*b.* What benefits or direct pay requirements otherwise mandated by state law may be exempted from coverage by a basic benefit coverage policy or subscription contract.

*c.* What cost-containment procedures must be minimally included in a basic benefit coverage policy or subscription contract.

*d.* What cost-containment measures otherwise restricted by state law may be utilized by a basic benefit coverage policy or subscription contract.

8. The commissioner may retain a consultant to assist in the analysis of any benefit or requirement and may convene an advisory panel to assist the commissioner in the review of evidence and practices by the health care and insurance industries.

*a.* The commissioner may assess a fee against carriers issuing or issuing for delivery in this state basic benefit coverage policies or subscription contracts to defray consulting fees and expenses incurred by the commissioner under this subsection.

*b.* The commissioner may also require medical professional societies or providers' associations requesting the inclusion of a benefit or requirement in a basic benefit coverage policy or subscription contract to contribute on a proportionate

and reasonable basis to the payment of the commissioner's consultants and expenses under this subsection as a condition of reviewing a benefit or requirement impacting upon such medical professionals or providers.

9. A benefit or direct pay requirement otherwise mandated by state law shall not be included in a basic benefit coverage policy or subscription contract unless the commissioner finds after actuarial review that the inclusion of the benefit or direct pay requirement is cost effective. The commissioner's finding shall be based upon review of actuarial evidence, including a cost-benefit analysis, and the determination that inclusion of the mandated benefit or direct pay requirement is in the best interests of providing affordable health care coverage.

10. A restriction on a cost-containment measure otherwise imposed by state law shall not apply to a basic benefit coverage policy or subscription contract unless the commissioner finds after actuarial review that the cost-containment measure is cost effective, and its exclusion is not in the best interests of providing affordable health care coverage.

11. As used in this section:

*a. "Basic benefit coverage"* means coverage of basic health care services rendered by health professionals licensed pursuant to state law together with hospital expenses.

*b. "Basic health care services"* means services which an enrollee might reasonably require in order to be maintained in good health, including at a minimum, emergency care, inpatient hospital and physician care, and outpatient services rendered within or outside of a hospital.

*c. "Carrier"* means the same as defined in section 513B.2.

*d. "Eligible dependent"* means an enrolled dependent of a subscriber entitled to coverage under a basic benefit coverage policy or subscription contract.

*e. "Policy"* means the entire contract between the insurer

and the insured, including the policy riders, endorsements, and the application, if attached, and includes individual subscriber contracts issued under chapter 514B.

*f. "Small employer"* means the same as defined in 513B.2.

EXPLANATION

This bill requires the commissioner of insurance, in cooperation with interested carriers, to develop by rule individual and small employer basic coverage policies or subscription contracts providing basic health benefit coverage to be targeted for sale to individuals under 30 years of age and their eligible dependents who have not had health care benefits within the preceding 12 months. "Basic benefit coverage" means coverage of basic health care services rendered by licensed health professionals together with hospital expenses. "Basic health care services" means services which an enrollee might reasonably require in order to be maintained in good health, including at a minimum, emergency care, inpatient hospital and physician care, and outpatient services rendered within or outside of a hospital.

A basic benefit coverage policy or subscription contract must include a disclosure statement including what mandated benefits and providers are not covered, the managed care and cost control features employed, and the term for which the policy or contract is in effect. All forms, policies, and contracts must be approved by the commissioner prior to the issuance or issuance for delivery of such policies or contracts in the state. The commissioner is required to determine what the cumulative loss ratio of such policies or contracts must be.

Records must be kept for each basic benefit policy or contract showing enrollment, claim costs, premium income, utilization, and other information as required by the commissioner. Each participating carrier must provide an annual report to the commissioner.

The commissioner may use reasonable actuarial evidence to

determine what benefits must be included in such coverage, what mandated benefits or direct pay requirements may be excluded, what cost-containment procedures must be employed, and what cost-containment measures otherwise restricted by state law may be utilized in providing such coverage.

The commissioner may retain consultants to assist in analysis of benefits and requirements and may assess a fee against participating carriers to defray those costs. The commissioner may also require medical societies or providers' associations requesting inclusion of a benefit or requirement to contribute to the cost of reviewing the request.

Benefits or direct pay requirements or restrictions on cost-containment measures imposed under state law are not required to be included in basic benefit policies or contracts unless determined to be cost effective and in the best interests of providing affordable health care coverage.